MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

Date of Birth: ____/____/_____

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____ Phone: _____

As my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION−MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

DESIGNATION OF ALTERNATE AGENT

(You are not required to designate an alternate agent, but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation automatically is revoked by law if your marriage is dissolved.) If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of this document is kept at: _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.
(If applicable) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED I revoke any prior Medical Power of Attorney.

ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement. (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Medical Power of Attorney on _____ day of

_____ (month) _____ (year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

STATEMENT OF FIRST WITNESS
I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or any employee of the attending physician. I have no claim againt any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner or business employee of the health care facility or of any parent organzation of the health care facility.

Signature:

_____
Print Name:
_____ Date: _____
Address:
_____

SIGNATURE OF SECOND WITNESS

Signature:

_____
Print Name:
_____ Date: _____
Address:
_____